

		FOR OHF USE					

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**2004**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2004)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0046037</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																									
<b>Facility Name:</b> <u>Palm Terrace of Mattoon</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
<b>Address:</b> <u>1000 Palm Avenue</u> <u>Mattoon</u> <u>61938</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
<b>County:</b> <u>Coles</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
<b>Telephone Number:</b> <u>(217) 234-7403</u> <b>Fax #</b> <u>(217) 258-6642</u>		<b>Paid Preparer</b> (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # (312) 634-5518																									
<b>IDPA ID Number:</b> <u>743055934001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
<b>Date of Initial License for Current Owners:</b> <u>11/01/2002</u>																											
<b>Type of Ownership:</b> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Christine A. Hanover</u> <b>Telephone Number:</b> <u>(312) 384-6000</u> Please send copies of desk review and audit adjustments to address on this page																											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Palm Terrace of Mattoon# 0046037 Report Period Beginning: 01/01/04 Ending: 12/31/04

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>178</u>	Skilled (SNF)	<u>178</u>	<u>65,148</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>178</u>	TOTALS	<u>178</u>	<u>65,148</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>37,165</u>	<u>3,140</u>	<u>1,455</u>	<u>41,760</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>37,165</u>	<u>3,140</u>	<u>1,455</u>	<u>41,760</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 64.10%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been  
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/01/2002

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 11/01/2002NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 14 and days of care provided 1,455Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Palm Terrace of Mattoon # 0046037 Report Period Beginning: 01/01/04 Ending: 12/31/04

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	168,150	17,836		185,986		185,986	9,094	195,080		1
2	Food Purchase		166,686		166,686		166,686	(1,944)	164,742		2
3	Housekeeping	116,646	29,677		146,323		146,323	38	146,361		3
4	Laundry	47,463	11,666		59,129		59,129	362	59,491		4
5	Heat and Other Utilities			182,482	182,482		182,482	989	183,471		5
6	Maintenance	46,023	48,322	12,513	106,858		106,858	9,208	116,066		6
7	Other (specify):* mgmt alloc of benefits							1,626	1,626		7
8	<b>TOTAL General Services</b>	378,282	274,187	194,995	847,464		847,464	19,373	866,837		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			38,360	38,360		38,360		38,360		9
10	Nursing and Medical Records	1,152,015	84,521	417	1,236,953		1,236,953	25,330	1,262,283		10
10a	Therapy			171,889	171,889		171,889	8	171,897		10a
11	Activities	33,096	353		33,449		33,449	9	33,458		11
12	Social Services	89,382	538		89,920		89,920		89,920		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* mgmt alloc of benefits							7,190	7,190		15
16	<b>TOTAL Health Care and Programs</b>	1,274,493	85,412	210,666	1,570,571		1,570,571	32,537	1,603,108		16
	<b>C. General Administration</b>										
17	Administrative	108,440		306,000	414,440		414,440	(194,418)	220,022		17
18	Directors Fees										18
19	Professional Services			13,780	13,780		13,780	37,995	51,775		19
20	Dues, Fees, Subscriptions & Promotions			9,938	9,938		9,938	4,061	13,999		20
21	Clerical & General Office Expenses	44,624	3,781	17,000	65,405		65,405	94,969	160,374		21
22	Employee Benefits & Payroll Taxes			279,978	279,978		279,978		279,978		22
23	Inservice Training & Education			145	145		145	1,219	1,364		23
24	Travel and Seminar			2,551	2,551		2,551	3,419	5,970		24
25	Other Admin. Staff Transportation			19,870	19,870		19,870	9,657	29,527		25
26	Insurance-Prop.Liab.Malpractice			91,452	91,452		91,452	2,395	93,847		26
27	Other (specify):* mgmt alloc of benefits							27,678	27,678		27
28	<b>TOTAL General Administration</b>	153,064	3,781	740,714	897,559		897,559	(13,025)	884,534		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,805,839	363,380	1,146,375	3,315,594		3,315,594	38,885	3,354,479		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Palm Terrace of Mattoon

#0046037

Report Period Beginning:

01/01/04

Ending:

12/31/04

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			36,697	36,697		36,697	16,668	53,365			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			144,716	144,716		144,716	39,029	183,745			32
33	Real Estate Taxes			30,362	30,362		30,362	591	30,953			33
34	Rent-Facility & Grounds							4,706	4,706			34
35	Rent-Equipment & Vehicles			21,694	21,694		21,694	(197)	21,497			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			233,469	233,469		233,469	60,797	294,266			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,492		43,492		43,492		43,492			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,722	97,722		97,722		97,722			42
43	Other (specify):* <b>Nonallowable Costs</b>			33,446	33,446		33,446	(33,446)				43
44	<b>TOTAL Special Cost Centers</b>		43,492	131,168	174,660		174,660	(33,446)	141,214			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,805,839	406,872	1,511,012	3,723,723		3,723,723	66,236	3,789,959			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Palm Terrace of Mattoon# 0046037Report Period Beginning: 01/01/04Ending: 12/31/04

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(1,947)	02		4
5 Telephone, TV & Radio in Resident Rooms	(12,323)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	2,757	30		9
10 Interest and Other Investment Income	(58)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(1,851)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(5,647)	43		24
25 Fund Raising, Advertising and Promotional	(6,208)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Schedule 5A	(8,127)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,404)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	99,640		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 99,640		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ 66,236		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

**Palm Terrace of Mattoon**

**Provider #: 0046037**

**01/01/04 to 12/31/04**

**Schedule 5A**

VI. Adjustment Detail

Line 29 - Other

Non-allowable expenses	Amount	Reference
Labs - Part A	(1,300)	43
X-Rays Part A	(258)	43
Special Events - Activities	(494)	43
Vending Machine	(1,262)	43
Other Expenses	(4,103)	43
Chamber of Commerce Dues	(710)	20
Total	(8,127)	

**SEE ACCOUNTANTS' COMPILATION REPORT**

Palm Terrace of Mattoon

ID# 0046037

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
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25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

12/31/04

[illegible]

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Palm Terrace of Mattoon# 0046037

Report Period Beginning:

01/01/04

Ending:

12/31/04

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	2,757	0	8,128	5,783	0	0	0	0	0	0	0	16,668	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(58)	0	9,289	29,798	0	0	0	0	0	0	0	39,029	32
33	Real Estate Taxes	0	0	603	(12)	0	0	0	0	0	0	0	591	33
34	Rent-Facility & Grounds	0	0	4,706	0	0	0	0	0	0	0	0	4,706	34
35	Rent-Equipment & Vehicles	0	0	165	0	0	0	0	0	0	0	0	165	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>2,699</b>	<b>0</b>	<b>22,891</b>	<b>35,569</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>61,159</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(26,029)	0	0	0	0	0	0	0	0	0	0	(26,029)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(26,029)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(26,029)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(25,277)</b>	<b>(134,174)</b>	<b>120,686</b>	<b>113,128</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>74,363</b>	<b>45</b>

Facility Name & ID Number Palm Terrace of Mattoon# 0046037

Report Period Beginning:

01/01/04

Ending:

12/31/04

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See attached Schedule 6A		See attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 9,094	\$ 9,094 1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	3	3 2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	38	38 3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	825	825 4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	5,680	5,680 5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,626	1,626 6
7	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	19,978	19,978 7
8	V	10A Therapy		Petersen Health Care, Inc.	100.00%	8	8 8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	9	9 9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,930	1,930 10
11	V	17 Administrative	306,000	Petersen Health Care, Inc.	100.00%	111,582	(194,418) 11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	20,155	20,155 12
13	V	20 Dues, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	898	898 13
14	Total		\$ 306,000			\$ 171,826	\$ * (134,174) 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Palm Terrace of Mattoon

# 0046037

Report Period Beginning: 01/01/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 68,945	\$ 68,945
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	1,150	1,150
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	2,441	2,441
18	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	4,691	4,691
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,641	1,641
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	18,927	18,927
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	8,128	8,128
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	9,289	9,289
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	603	603
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	4,706	4,706
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	165	165
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 120,686	\$ * 120,686

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Palm Terrace of Mattoon**# **0046037**Report Period Beginning: **01/01/04**Ending: **12/31/04****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	Petersen Health Care II, Inc.	0.00%	\$ 164	\$ 164
16	V	6 Maintenance		Petersen Health Care II, Inc.	0.00%	3,528	3,528
17	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	0.00%	5,352	5,352
18	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	5,260	5,260
19	V	19 Professional Services		Petersen Health Care II, Inc.	0.00%	17,840	17,840
20	V	20 Dues, Fees, Subs & Promos		Petersen Health Care II, Inc.	0.00%	3,873	3,873
21	V	21 Clerical & General Office		Petersen Health Care II, Inc.	0.00%	26,024	26,024
22	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	0.00%	69	69
23	V	24 Travel and Seminar		Petersen Health Care II, Inc.	0.00%	978	978
24	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	0.00%	4,966	4,966
25	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care II, Inc.	0.00%	754	754
26	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	8,751	8,751
27	V	30 Depreciation		Petersen Health Care II, Inc.	0.00%	5,783	5,783
28	V	32 Interest		Petersen Health Care II, Inc.	0.00%	29,798	29,798
29	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	0.00%	(12)	(12)
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 113,128	\$ * 113,128

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Palm Terrace of Mattoon  
Provider #0046307  
12/31/2004

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Arcola Health Care Center	Arcola, IL
Bement Health Care Center	Bement, IL
Casey Health Care Center	Casey, IL
Countryview Terrace	Louisville, IL
Eastview Terrace	Sullivan, IL
El Paso Health Care Center	El Paso, IL
Flora Health Care Center	Flora, IL
Havana Health Care Center	Havana, IL
Kewanee Care Home	Kewanee, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Royal Oaks Care Center	Kewanee, IL
Sheldon Health Care Center	Sheldon, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Tuscola Health Care Center	Tuscola, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
----------------------------	---------------

Related Assisted Living

Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL

Other Related Business Entities

Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Palm Terrace of Mattoon # 0046037 Report Period Beginning: 01/01/04 Ending: 12/31/04

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	981,407	5	10.00	Salary	\$ 111,582	L17,C8	1
2											2
3											3
4											4
5		See attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 111,582		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Palm Terrace of Mattoon  
 Provider #0046307  
 12/31/2004

Schedule 7A

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Casey Health Care Center	Countryview Terrace	Eastview Terrace	El Paso Health Care Center	Flora Health Care Center	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sheldon Health Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	Tuscola Health Care Center	TOTAL
Mark Petersen	90,072	55,013	25,865	15,145	58,361	74,717	10,659	72,956	69,335	54,095	111,582	77,674	64,047	91,387	33,271	68,050	101,105	19,655	1,092,989

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Palm Terrace of Mattoon# 0046037

Report Period Beginning:

01/01/04

Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Petersen Health Care Companies

Street Address

7218 North Villa Lake

City / State / Zip Code

Peoria, IL 61614

Phone Number

( 309) 691-8113

Fax Number

( 309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	409,056	18	\$ 89,079	\$ 89,071	41,760	\$ 9,093	1
2	2	Food	Patient Days	409,056	18	33		41,760	4	2
3	3	Housekeeping	Patient Days	409,056	18	372		41,760	38	3
4	5	Utilities	Patient Days	409,056	18	8,082		41,760	825	4
5	6	Maintenance	Patient Days	409,056	18	55,644	49,773	41,760	5,680	5
6	7	Mgmt. Allocation of Benefits	Patient Days	409,056	18	15,931		41,760	1,626	6
7	10	Nursing and Medical Records	Patient Days	409,056	18	195,694	164,789	41,760	19,978	7
8	10A	Therapy	Patient Days	409,056	18	75		41,760	8	8
9	11	Activities	Patient Days	409,056	18	86		41,760	9	9
10	15	Mgmt. Allocation of Benefits	Patient Days	409,056	18	18,908		41,760	1,930	10
11	17	Administrative	Patient Days	409,056	18	1,092,989	1,092,989	41,760	111,582	11
12	19	Professional Services	Patient Days	409,056	18	197,418		41,760	20,155	12
13	20	Dues, Fees, Subs & Promos	Patient Days	409,056	18	8,792		41,760	898	13
14	21	Clerical & General Office	Patient Days	409,056	18	675,343	522,789	41,760	68,945	14
15	23	Inservice Training & Education	Patient Days	409,056	18	11,260		41,760	1,150	15
16	24	Travel and Seminar	Patient Days	409,056	18	23,910		41,760	2,441	16
17	25	Other Admin. Staff Transport.	Patient Days	409,056	18	45,949		41,760	4,691	17
18	26	Insurance-Prop.Liab.Mal.	Patient Days	409,056	18	16,073		41,760	1,641	18
19	27	Mgmt. Allocation of Benefits	Patient Days	409,056	18	185,395		41,760	18,927	19
20	30	Depreciation	Patient Days	409,056	18	79,620		41,760	8,128	20
21	32	Interest	Patient Days	409,056	18	90,987		41,760	9,289	21
22	33	Real Estate Taxes	Patient Days	409,056	18	5,910		41,760	603	22
23	34	Rent - Facility & Grounds	Patient Days	409,056	18	46,102		41,760	4,706	23
24	35	Rent - Equipment & Vehicles	Patient Days	409,056	18	1,612		41,760	165	24
25	TOTALS					\$ 2,865,264	\$ 1,919,411		\$ 292,512	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Palm Terrace of Mattoon# 0046037

Report Period Beginning:

01/01/04Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Petersen Health Care II, Inc.Street Address 7218 North Villa LakeCity / State / Zip Code Peoria, IL 61614Phone Number ( 309) 691-8113Fax Number ( 309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	115,099	5	\$ 41,760	\$ 41,760	\$ 164	1
2	6	Maintenance	Patient Days	115,099	5	9,723	41,760	3,528	2
3	10	Nursing and Medical Records	Patient Days	115,099	5	14,750	41,760	5,352	3
4	15	Mgmt. Allocation of Benefits	Patient Days	115,099	5	14,497	41,760	5,261	4
5	19	Professional Services	Patient Days	115,099	5	49,169	41,760	17,839	5
6	20	Dues, Fees, Subs & Promos	Patient Days	115,099	5	10,675	41,760	3,873	6
7	21	Clerical & General Office	Patient Days	115,099	5	71,727	41,760	26,024	7
8	23	Inservice Training & Education	Patient Days	115,099	5	190	41,760	69	8
9	24	Travel and Seminar	Patient Days	115,099	5	2,696	41,760	978	9
10	25	Other Admin. Staff Transport.	Patient Days	115,099	5	13,686	41,760	4,966	10
11	26	Insurance-Prop.Liab.Mal.	Patient Days	115,099	5	2,077	41,760	754	11
12	27	Mgmt. Allocation of Benefits	Patient Days	115,099	5	24,119	41,760	8,751	12
13	30	Depreciation	Patient Days	115,099	5	15,940	41,760	5,783	13
14	32	Interest	Patient Days	115,099	5	82,129	41,760	29,798	14
15	33	Real Estate Taxes	Patient Days	115,099	5	(33)	41,760	(12)	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 311,796	\$ 39,291	\$ 113,128	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Palm Terrace of Mattoon# 0046037

Report Period Beginning:

01/01/04

Ending:

12/31/04

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Associated Bank		X	Mortgage	\$14,075.65	9/20/03	\$ 1,611,250	\$ 0	09/20/33	0.0645	\$ 131,951	1	
2	Associated Bank		X	Vehicle	\$544.28	5/9/03	18,000	8,870	05/09/08	0.0550	974	2	
3	US Bank		X	Mortgage	\$52,952+interest	12/31/04	4,448,000	4,448,000	12/31/11	0.0699	0	3	
4	Bank of Farmington		X	Vehicle	\$467.00	05/01/04	16,806	12,180	04/30/07	0.0590	421	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$15,086.93		\$ 6,094,056	\$ 4,469,050			\$ 133,346	9	
	B. Non-Facility Related*												
10								Home office allocation			39,087	10	
11								Amortization of loan costs			11,370	11	
12								Offset interest income			(58)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 50,399	14	
15	TOTALS (line 9+line14)						\$ 6,094,056	\$ 4,469,050			\$ 183,745	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ -0- Line # N/A\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Palm Terrace of Mattoon**# **0046037** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2003 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>28,500</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2003	\$	<b>29,431</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>931</b>	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>29,431</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
<b>TOTAL REFUND \$</b> _____ <b>For</b> _____ <b>Tax Year.</b> <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		Home Office Allocation	\$	<b>591</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>30,953</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1999	<b>40,467</b>	8		
	2000	<b>41,675</b>	9		
	2001	<b>20,752</b>	10		
	2002	<b>28,492</b>	11		
	2003	<b>29,431</b>	12		
				<b>FOR OHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Palm Terrace of Mattoon COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0046037

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE ( 217 ) 234-7403 FAX #: ( 217 ) 258-6642

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>07-1-00908-000</u>	<u>Palm Terrace of Mattoon</u>	<u>\$ 29,431.00</u>	<u>\$ 29,431.00</u>
2.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
3.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
4.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
5.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
6.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
7.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
8.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
9.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
10.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
		<b>TOTALS</b>	<b>\$ <u>29,431.00</u></b>	<b>\$ <u>29,431.00</u></b>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?            YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:
 44,000

B. General Construction Type:
 Exterior
 Brick & block
 Frame
 Number of Stories
 One

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 N/A

2. Number of Years Over Which it is Being Amortized:
 N/A

3. Current Period Amortization:
 N/A

4. Dates Incurred:
 N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	44,000	2002	\$ 32,860	1
2					2
3	TOTALS	44,000		\$ 32,860	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Palm Terrace of Mattoon

# 0046037

Report Period Beginning:

01/01/04

Ending:

12/31/04

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	178	2002	1969	\$ 528,492	\$ 13,551	39	\$ 13,551	\$ 0	\$ 24,844
5									
6									
7									
8									
9	Improvement Type**								
10	Alzheimer's unit renovation	2003		4,026	103	39	103	0	125
11	Alzheimer's unit renovation	2003		26,810	1,787	15	1,787	0	1,935
12	Roof	2004		7,814	8	39	100	92	100
13	Boiler	2004		4,019	4	39	52	48	52
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 571,161	\$ 15,453		\$ 15,593	\$ 140	\$ 27,056	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

Facility Name &amp; ID Number Palm Terrace of Mattoon

# 0046037

Report Period Beginning:

01/01/04

Ending:

12/31/04

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 63,208	\$ 9,585	\$ 12,642	\$ 3,057	5	\$ 16,926	71
72	Current Year Purchases	22,070	1,419	2,207	788	5	2,207	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			13,911	13,911			74
75	TOTALS	\$ 85,278	\$ 11,004	\$ 28,760	\$ 17,756		\$ 19,133	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2002 Jetta	2003	\$ 17,080	\$ 3,416	\$ 3,416		5	\$ 5,124	76
77	Facility	2003 Dodge Truck	2003	20,300	4,060	4,060		5	5,752	77
78	Facility	2000 Ford Truck E150	2004	15,362	1,920	1,536	(384)	5	1,536	78
79										79
80	TOTALS			\$ 52,742	\$ 9,396	\$ 9,012	\$ (384)		\$ 12,412	80

## E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 742,041	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,853	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 53,365	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,512	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 58,601	85

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

## G. Construction-in-Progress

	Description	Cost	
92	Alzheimer's Unit Renovation	\$ 258,974	92
93			93
94			94
95		\$ 258,974	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		Home office allocation			4,706			6
7	TOTAL				\$ 4,706			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A  
N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 21,497 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning                       
Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2005 \$                       
13.                      /2006 \$                       
14.                      /2007 \$                     

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18		N/A			18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**Palm Terrace of Mattoon**  
**Provider #0046307**  
**12/31/2004**

**Schedule 14A**

XII. Rental Equipment  
Line 16

<u>Type of Equipment</u>	<u>Cost</u>
Home Office Allocation	165
Special Mattresses	4648
Wound Care Vacuum	3351
Compressor System	3138
Respiratory Equipment	370
CPM Rental	227
Laundry Equipment	101
Propane Tank Rental	37
Signs	3200
Copy Machines	6260
	<u>\$ 21,497</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A,C3	hrs	\$	3,661	\$ 62,237	\$	3,661	\$ 62,237	1
2	Licensed Speech and Language Development Therapist	L10A,C3	hrs		663	23,221		663	23,221	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		4,621	83,183		4,621	83,183	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				33,899		33,899	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):   Oxygen	L39, C2					9,593		9,593	13
14	TOTAL			\$	8,946	\$ 168,641	\$ 43,492	8,946	\$ 212,133	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Palm Terrace of Mattoon

# 0046037

Report Period Beginning: 01/01/04

Ending:

12/31/04

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,996,032	\$ 2,996,032	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u> )	919,970	919,970	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,098	6,098	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	536,614	536,614	9
	<b>TOTAL Current Assets</b>			
10	(sum of lines 1 thru 9)	\$ 4,458,714	\$ 4,458,714	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	36,886	32,860	13
14	Buildings, at Historical Cost	528,492	528,492	14
15	Leasehold Improvements, at Historical Cost	38,643	42,669	15
16	Equipment, at Historical Cost	138,020	138,020	16
17	Accumulated Depreciation (book methods)	(58,719)	(58,601)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>Construction in Progress</u> )	258,974	258,974	22
23	Other(specify): <u>Security Deposit</u>	8,051	8,051	23
	<b>TOTAL Long-Term Assets</b>			
24	(sum of lines 11 thru 23)	\$ 950,347	\$ 950,465	24
	<b>TOTAL ASSETS</b>			
25	(sum of lines 10 and 24)	\$ 5,409,061	\$ 5,409,179	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 315,648	\$ 315,648	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	119,478	119,478	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,431	29,431	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	26,543	26,543	36
37				37
	<b>TOTAL Current Liabilities</b>			
38	(sum of lines 26 thru 37)	\$ 491,100	\$ 491,100	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	21,050	21,050	39
40	Mortgage Payable	4,448,000	4,448,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
	<b>TOTAL Long-Term Liabilities</b>			
45	(sum of lines 39 thru 44)	\$ 4,469,050	\$ 4,469,050	45
	<b>TOTAL LIABILITIES</b>			
46	(sum of lines 38 and 45)	\$ 4,960,150	\$ 4,960,150	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 448,911	\$ 449,029	47
	<b>TOTAL LIABILITIES AND EQUITY</b>			
48	(sum of lines 46 and 47)	\$ 5,409,061	\$ 5,409,179	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Palm Terrace of Mattoon**

**Provider #: 0046037**

**01/01/04 to 12/31/04**

**Schedule 16A**

XIV. Special Services

Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
----------------	---------------------------	-------------------------------------	-------------	-----------------

**SEE ACCOUNTANTS' COMPILATION REPORT**

Palm Terrace of Mattoon  
Provider #0046307  
12/31/2004

Schedule 17A

XV. Balance Sheet - Unrestricted Operating Funds

A. Current Assets

<u>Other Current Assets:</u>	<u>Opertating</u>	<u>Consolidation</u>
Due from prior owner	2,057	2,057
Acc. Insurance - W/C	4,509	4,509
Due from related parties	530,048	530,048
Total Line 9 - Other Current Assets	<u>536,614</u>	<u>536,614</u>

C. Current Liabilities

<u>Other Current Liabilities:</u>	<u>Opertating</u>	<u>Consolidation</u>
Accrued Insurance -General	7,035	7,035
Accrued Interest	13,811	13,811
Accrued Sales Tax	849	849
Other	4,848	4,848
Total Line 36 - Other Current Liabilities	<u>26,543</u>	<u>26,543</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 75,237</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>(9,200)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 66,037</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>382,874</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 382,874</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 448,911</b>	<b>24</b>

Operating Entity Only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Palm Terrace of Mattoon

# 0046037

Report Period Beginning: 01/01/04

Ending:

12/31/04

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,658,356	1
2	Discounts and Allowances for all Levels	72,121	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,730,477	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	306,417	6
7	Oxygen	19,706	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 326,123	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,947	14
15	Telephone, Television and Radio	5,628	15
16	Rental of Facility Space		16
17	Sale of Drugs	36,052	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,873	20
21	Other Medical Services	1,650	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 47,150	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	58	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 58	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Transportation</b>	2,789	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,789	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,106,597	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	847,464	31
32	Health Care	1,570,571	32
33	General Administration	897,559	33
<b>B. Capital Expense</b>			
34	Ownership	233,469	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	76,938	35
36	Provider Participation Fee	97,722	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,723,723	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	382,874	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 382,874	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
Entity is a cash basis taxpayer

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Palm Terrace of Mattoon  
Provider #0046307  
12/31/2004

Schedule 19A

XVII. Income Statement  
Revenue

<u>E. Other Revenue</u>	<u>Amount</u>
-------------------------	---------------

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number **Palm Terrace of Mattoon**# **0046037**Report Period Beginning: **01/01/04**

Ending:

**12/31/04****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,573	2,649	\$ 58,148	\$ 21.95	1
2	Assistant Director of Nursing	788	788	13,362	16.96	2
3	Registered Nurses	3,391	3,463	74,497	21.51	3
4	Licensed Practical Nurses	21,201	21,491	363,240	16.90	4
5	Nurse Aides & Orderlies	61,702	63,993	600,689	9.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,872	1,872	14,338	7.66	9
10	Activity Assistants	2,378	2,378	18,758	7.89	10
11	Social Service Workers	6,828	6,844	89,382	13.06	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,160	40,625	18.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,611	18,016	127,525	7.08	15
16	Dishwashers					16
17	Maintenance Workers	4,771	4,771	46,023	9.65	17
18	Housekeepers	16,964	17,321	116,646	6.73	18
19	Laundry	5,631	5,969	47,463	7.95	19
20	Administrator	1,820	1,820	73,190	40.21	20
21	Assistant Administrator	2,167	2,167	35,250	16.27	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,106	4,205	44,624	10.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Plan Coord	2,287	2,311	42,079	18.21	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,170	162,218	\$ 1,805,839 *	\$ 11.13	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	monthly	38,360	L9, C3	36
37	Medical Records Consultant	5	118	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	299	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	monthly	3,248	L10A, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5	\$ 42,025		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

**Palm Terrace of Mattoon**  
**Provider #: 0046307**  
**1/1/2004 to 12/31/2004**

Schedule 20A

VIII. Staffing and Salary Costs

Line 32 - Other Health Care (specify)

	Hours Worked	Hours Paid	Salary	Avg. Hr. Wage
Care Plan Coordinator				
Transportation				
	-	-	-	

**SEE ACCOUNTANTS' COMPILATION REPORT**

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount			
Theresa Gowin	Administrator	0	\$ 73,190	Workers' Compensation Insurance		\$ 63,263	IDPH License Fee	\$ 3,600			
Angela Edwards	Asst. Administrator	0	35,250	Unemployment Compensation Insurance		25,490	Advertising; Employee Recruitment	4,534			
				FICA Taxes		135,367	Health Care Worker Background Check (Indicate # of checks performed <u>40</u> )	408			
				Employee Health Insurance		52,527	Miscellaneous dues	255			
				Employee Meals		0	Miscellaneous licenses	256			
				Illinois Municipal Retirement Fund (IMRF)*			Mes of Illinois	175			
				Employee relations		2,487	Allocation from Management Co	4,771			
				401 (k) match		844					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)											
\$ 108,440											
B. Administrative - Other											
Description			Amount								
Management Fees (eliminated in column 7)			\$ 306,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)											
\$ 306,000											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
Bush, Snyder & Assoc	Legal		\$ 1,581	N/A			Out-of-State Travel	\$			
Altschuler Melvoin & Glasser	Accounting		5,575								
P.K. Bhosale	Architect		1,035								
ADP	Payroll service		3,512				In-State Travel	2,351			
Ivans	Computer service		538								
LTC Solutions	Computer service		1,320								
Other	Computer service		219								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)				
\$ 13,780				\$			\$ 5,970				

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**Palm Terrace of Mattoon**

**Provider #: 0046037**

**01/01/04 to 12/31/04**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

Total (agree to Schedule V, line 19, column 3) 13,780

Allocated from Management Company

Legal 3,408

Other 34,587

Total (agree to Schedule V, line 19, column 8) 51,775

**SEE ACCOUNTANTS' COMPILATION REPORT**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,752 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 97,722  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,947
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit is in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	168,150	17,836	0	185,986	0	185,986	9,094	195,080
2. Food Purchase	0	166,686	0	166,686	0	166,686	-1,944	164,742
3. Housekeeping	116,646	29,677	0	146,323	0	146,323	38	146,361
4. Laundry	47,463	11,666	0	59,129	0	59,129	362	59,491
5. Heat and Other Utilities	0	0	182,482	182,482	0	182,482	989	183,471
6. Maintenance	46,023	48,322	12,513	106,858	0	106,858	9,208	116,066
7. Other (specify)*	0	0	0	0	0	0	1,626	1,626
8. Total General Services	378,282	274,187	194,995	847,464	0	847,464	19,373	866,837
9. Medical Director	0	0	38,360	38,360	0	38,360	0	38,360
10. Nursing & Medical Records	1,152,015	84,521	417	1,236,953	0	1,236,953	25,330	1,262,283
10a. Therapy	0	0	171,889	171,889	0	171,889	8	171,897
11. Activities	33,096	353	0	33,449	0	33,449	9	33,458
12. Social Services	89,382	538	0	89,920	0	89,920	0	89,920
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	7,190	7,190
16. Total Health Care & Programs	1,274,493	85,412	210,666	1,570,571	0	1,570,571	32,537	1,603,108
17. Administrative	108,440	0	306,000	414,440	0	414,440	-194,418	220,022
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	13,780	13,780	0	13,780	37,995	51,775
20. Fees, Subscriptions & Promotion	0	0	9,938	9,938	0	9,938	4,061	13,999
21. Clerical & General Office	44,624	3,781	17,000	65,405	0	65,405	94,969	160,374
22. Employee Benefits & Payroll	0	0	279,978	279,978	0	279,978	0	279,978
23. Inservice Training & Education	0	0	145	145	0	145	1,219	1,364
24. Travel and Seminar	0	0	2,551	2,551	0	2,551	3,419	5,970
25. Other Admin. Staff Trans	0	0	19,870	19,870	0	19,870	9,657	29,527
26. Insurance-Prop.Liab.Malpractice	0	0	91,452	91,452	0	91,452	2,395	93,847
27. Other (specify)*	0	0	0	0	0	0	27,678	27,678
28. Total General Adminis	153,064	3,781	740,714	897,559	0	897,559	-13,025	884,534
29. Total General Administrative	1,805,839	363,380	1,146,375	3,315,594	0	3,315,594	38,885	3,354,479
30. Depreciation	0	0	36,697	36,697	0	36,697	16,668	53,365
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	144,716	144,716	0	144,716	39,029	183,745
33. Real Estate	0	0	30,362	30,362	0	30,362	591	30,953
34. Rent - Facility & Grounds	0	0	0	0	0	0	4,706	4,706
35. Rent - Equipment & Vehicles	0	0	21,694	21,694	0	21,694	-197	21,497
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	233,469	233,469	0	233,469	60,797	294,266
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	43,492	0	43,492	0	43,492	0	43,492
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	97,722	97,722	0	97,722	0	97,722
43. Other (specify):*	0	0	33,446	33,446	0	33,446	-33,446	0
44. Total Special Cost Ce	0	43,492	131,168	174,660	0	174,660	-33,446	141,214
45. Grand Total	1,805,839	406,872	1,511,012	3,723,723	0	3,723,723	66,236	3,789,959

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	2,996,032	2,996,032
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	919,970	919,970
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	6,098	6,098
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	536,614	536,614
10. Total current assets	4,458,714	4,458,714
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	36,886	32,860
14. Buildings, at Historical Cost	528,492	528,492
15. Leasehold Improvements, Historical Cost	38,643	42,669
16. Equipment, at Historical Cost	138,020	138,020
17. Accumulated Depreciation (book methods)	-58,719	-58,601
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	258,974	258,974
23. other (specify):	8,051	8,051
24. Total Long-Term Assets	950,347	950,465
25. Total Assets	5,409,061	5,409,179
CURRENT LIABILITIES		
26. Accounts Payable	315,648	315,648
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	119,478	119,478
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	29,431	29,431
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	26,543	26,543
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	491,100	491,100
LONG TERM LIABILITES		
39.Long-Term Notes Payable	21,050	21,050
40.Mortgage Payable	4,448,000	4,448,000
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	4,469,050	4,469,050
46.Total Liabilities	4,960,150	4,960,150
47.Total Equity	448,991	449,029
48.Total Liabilities and Equity	5,409,141	5,409,179

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,658,356
2. Discounts and Allowances for all Levels	72,121
Subtotal - Inpatient Care	3,730,477
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	306,417
7. Oxygen	19,706
Subtotal - Ancillary Revenue	326,123
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,947
15. Telephone, Television, and Radio	5,628
16. Rental of Facility Space	0
17. Sale of Drugs	36,052
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	1,873
21. Other Medical Services	1,650
22. Laundry	0
Subtotal - Other Operating Revenue	47,150
24. Contributions	0
25. Interest and Other Investments Income	58
Subtotal - Non-Operating Revenue	58
27. Other Revenue (specify):	2,789
28. Other Revenue (specify):	0
Subtotal - Other Revenue	2,789
30. Total Revenue	4,106,597
31. General Services	847,464
32. Health Care	1,570,571
33. General Administration	897,559
34. Ownership	233,469
35. Special Cost Centers	76,938
35. Provider Participation Fee	97,722
37. Other	0
40. Total Expenses	3,723,723
41. Income Before Income Taxes	382,874
42. Income Taxes	0
43. Net Income or Loss for the Year	382,874

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